U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 13 October 2005

In the Matter of:

LANDON B. LUSK,
Claimant

Case No. 2003-BLA-6035

v.

EASTERN ASSOCIATED COAL CORP.,
Employer

and

PEABODY INVESTMENTS, INC.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

S. F. Raymond Smith, Esquire
Rundle & Rundle
Pineville, West Virginia
For the Claimant

Paul Frampton, Esquire
Bowles, Rice, McDavid, Graff & Love
Morgantown, West Virginia
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 C.F.R. Parts 410, 718, 725 and

727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 C.F.R. § 718.201 (2005). In this case, Landon Lusk ("Claimant") alleges that he is totally disabled by coal workers' pneumoconiosis ("CWP").

I conducted a hearing on this claim on August 11, 2004, in Beckley, West Virginia. All parties were afforded full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 C.F.R. Part 18 (2005). At the hearing, Claimant was the only witness. Transcript ("Tr.") at 12–29. Director's Exhibits ("DX") 1–30 and Employer's Exhibits ("EX") 1–5 were admitted into evidence without objection. Tr. at 7, 10–11. No parties submitted closing arguments, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence and the testimony at hearing.

PROCEDURAL HISTORY

The Claimant filed the instant claim on July 12, 2001. DX 2. The District Director of the Office of Workers' Compensation Programs ("OWCP") awarded benefits to Claimant on March 17, 2003. DX 23. Employer appealed that determination and requested a formal hearing on March 24, 2003. DX 24.

APPLICABLE STANDARDS

This claim was filed after March 31, 1980, and after January 19, 2001, the effective date of the current regulations. For this reason, the current regulations at 20 C.F.R. Parts 718 and 725 apply. 20 C.F.R. §§ 718.2 and 725.2 (2005). In order to establish entitlement to benefits under Part 718, Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his coal workers' pneumoconiosis is totally disabling. 20 C.F.R. §§ 718.1, 718.202, 718.203 and 718.204 (2005).

ISSUES

The parties stipulated that Claimant has established 33 years and 4 months of coal mine employment and that his last coal mine employment was with Eastern Coal Co. The parties also stipulated that Claimant has one dependent for purposes of augmentation of benefits. Tr. at 5–6, 20. The contested issues are as follows:

1. Whether Claimant has pneumoconiosis as defined by the Act and the regulations;

2. Whether his pneumoconiosis arose out of coal mine employment;

3. Whether he is totally disabled; and

4. Whether his total disability is due to pneumoconiosis.

DX 28; Tr. at 5–6. The Employer also reserved its right to challenge the statute and regulations. Tr. at 6–7.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Mr. Lusk testified that he was born in 1937 and that he is currently married to Lynetta Jean Lusk. Tr. at 13–14. His last coal mine employment took place in West Virginia. Tr. at 14. Therefore this claim is governed by the law of the Fourth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (*en banc*). Claimant testified that he worked underground for twenty years as a face supervisor at Eastern Coal Co. Tr. at 14. He last worked in the mines in 1991. DX 3-4. He performed manual labor and often helped to lift and carry items weighing as much as 300–400 pounds. Tr. at 23. He would spend most of his day underground supervising and conducting inspections. Tr. at 26.

Claimant stated that he smoked ½ pack of cigarettes per day, on and off, for about 20 years, and quit in the late 1970s. Tr. at 17. He currently uses inhalers and takes blood pressure medication. Tr. at 19–20.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may be classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b) (2005). Any such readings are therefore included in the "negative" column. An x-ray interpretation which made no reference to pneumoconiosis, positive or negative, given in connection with review of an x-ray film solely to determine its quality, is listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications of physicians are abbreviated as follows: B = NIOSH[1] certified B-reader; BCR = board-certified in radiology. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n.16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
12/05/01		EX 4 Wheeler/BCR, B 0/1	
04/25/02	DX 12 Patel/BCR, B 1/1 "B" opacities	EX 2 Scott/BCR, B	DX 13 Binns/BCR, B Bilateral large opacities, cannot rule out neoplasm
01/06/04		EX 3 Scatarige/BCR, B	

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). Mr. Lusk testified that after a doctor reported that he had irregularities on his lungs that should be looked into, his own doctor recommended a CT scan and a PET scan. The original reports of those tests, which Mr. Lusk believed to be negative for a tumor, are not in the file. However, three board certified radiologists who are also B readers read the CT scan taken on January 6, 2004, on behalf of the Employer. Their interpretations are found at EX 1.

Dr. Paul Wheeler stated that the CT scan revealed no silicosis or CWP. He observed two large masses, one 7 cm, and the other 6 cm. He thought conglomerate tuberculosis to be the more likely cause than histoplasmosis. He also observed moderate bullous blebs in the right lung, and emphysema in both lungs. He went on to state:

> Calcifications in upper lobe masses and lack of background small nodules is against large opacities CWP. Very rarely all small nodules are merged into large opacities but that

[1]The National Institute of Occupational Safety and Health (NIOSH) is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination.

would require high unprotected dust exposure which occurred in drillers during and before WW2. Check exposure and protection.

Dr. William Scott reported emphysema with bullous changes in the upper zones. He also observed two large masses, 10 cm in the right upper lung and 6 cm in the left upper lung. He said they probably represented granulomatous masses due to tuberculosis. He also said, "Silicotuberculosis with large opacities is a less likely possibility due to the lack of a small-nodular background."

Finally, Dr. John Scatarige also opined that there were no background small round opacities to suggest CWP or silicosis. He described the masses as 6 x 7 cm on the right, and 4 x 6 cm on the left. Differential diagnoses were conglomerate TB, sarcoidosis, and lung cancer. He went on to re-state that he doubted silicosis or CWP absent small round opacities, and suggested comparison with prior x-rays to establish stability of the large masses over time. He advised biopsy if they had increased in diameter. He, too, identified emphysema in addition to the large masses.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 C.F.R. § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
EX 5 12/05/01 Zaldivar	64 69"	2.07 2.30	4.07 3.99	51 57	77 85	No No	Moderate irreversible obstruction; normal lung volume; normal diffusion
DX 10 04/25/02 Mullins	65 69"	1.62 1.80	3.65 3.51	44 51	62 —	Yes No	Good effort on both tests

Dr. Dominic Gaziano validated the results of the April 25, 2002 pulmonary function study in a report dated July 2, 2002. DX 11. Dr. Gaziano is board-certified in Internal Medicine and Pulmonary Diseases.

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (pO_2) and the percentage of carbon dioxide (pCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in connection with his current claim. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b) (2005).

Exhibit Number	Date	Physician	pCO_2 at rest/ exercise	pO_2 at rest/ exercise	Qualify?	Physician Impression
EX 5	12/05/01	Zaldivar	30 32	97 87	No No	—
DX 9	04/25/02	Mullins	37.7 39.6	74.3 76.6	No No	Patient became too short of breath and fatigued to continue riding; unable to reach target heart rate of 135

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned

medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 C.F.R. § 718.204(b)(2)(iv) (2005). With certain specified exceptions which do not apply here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 C.F.R. § 718.204(c)(2) (2005). The record contains the following medical opinion relating to this case.

Dr. Norma J. Mullins examined Mr. Lusk on behalf of the Department of Labor on April 25, 2002. DX 8. Dr. Mullins is board-certified in internal medicine and pulmonary disease. She took occupational, social, family and medical histories, and conducted a physical examination, chest x-ray, blood gas studies and pulmonary function testing. She reported that Mr. Lusk worked in the mines for 35 years as a section foreman. She reported a smoking history of ½ pack of cigarettes per day for 24 years, ending in 1976. The chest examination was normal. Dr. Mullins noted that the chest x-ray showed pneumoconiosis "1/1." The pulmonary function test showed a moderate ventilatory impairment. Dr. Mullins diagnosed coal workers' pneumoconiosis by chest x-ray and noted "probably early PMF [progressive massive fibrosis] by c[hest] x-ray." Her diagnoses also included chronic obstructive pulmonary disease ("COPD") with a reversible component, and atrial fibrillation "by history." Based upon her examination, Dr. Mullins concluded that Claimant has a "moderate ventilatory impairment, which even after allowing for reversible component remaining in moderate range [and] prob[ably] would have interfered with last job. Pt. likely has early PMF which will progress." She attributed the ventilatory impairment as follows: "75% CWP; 25% other."

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.
>
> (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2005). In this case, Dr. Mullins diagnosed Claimant with clinical pneumoconiosis, as well as chronic obstructive pulmonary disease, which can be encompassed within the definition of legal pneumoconiosis. 20 C.F.R. § 718.201(a)(2) (2005); *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003). This will be discussed in further detail below.

20 C.F.R. § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray; (2) biopsy or autopsy; (3) application of the presumptions described in §§ 718.304 (irrebuttable presumption of total disability/that a miner's death was due to pneumoconiosis if there is a showing of complicated pneumoconiosis) or 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978); or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. There is no evidence that Claimant has had a lung biopsy, and, of course, no autopsy has been performed. None of the presumptions apply, because, as will be discussed below, the evidence does not establish the existence of complicated pneumoconiosis, Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays, medical opinions, and the CT scans. Absent contrary evidence, evidence relevant to either category may establish the existence of pneumoconiosis. In the face of conflicting evidence, however, I must weigh all of the evidence together in reaching my finding whether Claimant has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22 (3rd Cir. 1997).

Pursuant to § 718.304(a) the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under § 718.304. Its existence may also be established under § 718.304 (b) by biopsy or autopsy or pursuant to § 718.304 (c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under § 718.304 has been established. *Melnick v. Consolidated Coal Co*., 16 B.L.R. 1-31, 1-33 (1991) (en banc). The United States Court of Appeals for the Fourth

Circuit has held that "…even where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) [biopsy or autopsy] or prong (C) [other means] then all the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray." *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F. 3d 250, 256 (4th Cir. 2000).

In this case, there is no biopsy or autopsy evidence. However, in her April 26, 2002 report, Dr. Mullins wrote that Claimant "likely has early PMF which will progress." This finding is explicitly based on the April 25, 2002 chest x-ray report by Dr. Patel. In this report, Dr. Patel noted the presence of large "B" opacities in the film of the same date. However, this same chest x-ray was read as negative by one other dually-qualified radiologist. The radiologist who read the x-ray for its quality only also noted the presence of large opacities, but reported that neoplasm could not be ruled out. I find that the April 2002 x-ray evidence is inconclusive at best. Although all of the doctors who read the CT scan for the Employer also noted the presence of two large masses, none thought they represented complicated pneumoconiosis. Moreover, Dr. Mullins' reliance on the April 2002 x-ray reading by Dr. Patel, without access to the other x-ray or CT readings, undermines her diagnosis of complicated pneumoconiosis. I find that the weight of the evidence as a whole does not support a diagnosis of complicated pneumoconiosis, and therefore, does not invoke the Section 304 presumption of total disability due to pneumoconiosis.

I now turn to consider whether the evidence otherwise establishes the presence of pneumoconiosis.

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314–315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151–152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258–259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148–1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319–320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The x-ray taken on December 5, 2001 was read as negative by Dr. Wheeler, a dually-qualified physician. There are no positive readings. I therefore find this x-ray to be negative for pneumoconiosis.

The x-ray taken on April 25, 2002 was read as positive by a dually-qualified physician and as negative by a dually-qualified physician. As discussed above, Dr. Patel read the film as

positive and noted the presence of large "B" opacities. The other dually-qualified physician read it as negative for the presence of even simple pneumoconiosis. A third dually-qualified physician, Dr. Binns, who read the film for quality, made no reference to the presence or absence of pneumoconiosis but simply wrote: "bilateral large opacities; cannot [rule out] neoplasm." I find that this x-ray is inconclusive as to the presence of simple or complicated pneumoconiosis.

The x-ray taken on January 6, 2004 was read as negative by a dually qualified physician. There are no positive readings. I therefore find this x-ray to be negative for pneumoconiosis.

These constitute all of the x-ray interpretations in the record pertaining to the claim. I have found two of them to be negative and one to be inconclusive. I find that the x-ray evidence as a whole does not support a positive finding of pneumoconiosis.

I must next consider the medical opinions. Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp*., 6 B.L.R. 1-1291, 1-1294 (1984). In this case, Dr. Mullins provided the only medical opinion regarding the existence of pneumoconiosis apart from the x-ray and CT scan interpretations by radiologists. Her opinion was based on a history, examination and test results. Although I have rejected her diagnosis of complicated pneumoconiosis because other evidence, which was not available to her, did not support it, I find her report to be otherwise sufficiently well-documented and reasoned to rely on it.

In addition to her diagnosis of progressive massive fibrosis, Dr. Mullins also made a finding of COPD, which she attributed to "CWP and asthma." Dr. Mullins' diagnosis of COPD is supported by the findings of emphysema on all of the x-ray readings. Dr. Wheeler and Dr. Scatarige also included a diagnosis of emphysema in their readings of the CT scan. That diagnosis is also supported by the results of the pulmonary function tests. There is no medical opinion of record that coal dust did not contribute to the Claimant's COPD. I credit Dr. Mullins' diagnosis of COPD caused by exposure to coal dust, which meets the definition of legal pneumoconiosis found in the regulations. *See also Warth v. Southern Ohio Coal Co*., 60 F.3d 173.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 C.F.R. § 718.203(b) (2005). Claimant was employed as a miner for over 33 years, and therefore is entitled to the presumption. The Employer has not offered any evidence to rebut the presumption. Moreover, although the Claimant was once a smoker, the record indicates that he smoked ½ pack per day or less, and stopped smoking in the late 1970's, many years before he left the mines. I find that the evidence shows that there is a causal relationship between the Claimant's pneumoconiosis and his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 C.F.R. § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 C.F.R. § 718.204(b), (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 C.F.R. § 718.204(b), (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 C.F.R. § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). I have determined that the Claimant does not have complicated pneumoconiosis. There is no evidence in the record that Mr. Lusk suffers from cor pulmonale. Thus I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 C.F.R. § 718.204(b)(2) (2005); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

Of the two pulmonary function studies of record, only the pre-bronchodilator values on the April 25, 2002 study produced qualifying values. Although this study was the most recent and was validated by Dr. Gaziano, the pulmonary function study from only five months before did not produce qualifying values. I find that the pulmonary function study evidence as a whole is not sufficient to establish total disability.

No arterial blood gas study of record produced qualifying values. Therefore, the arterial blood gas studies do not support a finding of total respiratory disability. As the blood gas studies measure a different aspect of lung function, however, they do not contradict the existence of an impairment of lung function suggested by the results of the pulmonary function studies.

Only Dr. Mullins' opinion whether the Claimant has a total pulmonary or respiratory disability has been offered into evidence. She wrote that Claimant's impairment "probably would have interfered with performance of his last job." Although this statement is somewhat equivocal, there is no contrary medical opinion in the record that the Claimant *would* have been able to perform the same or similar work, which, according to the Claimant's testimony, required considerable effort to perform. I therefore conclude that Dr. Mullins' opinion supports the conclusion that the Claimant is disabled.

Weighing all of the evidence together on this issue, I find that the Claimant has borne his burden to establish that he is totally disabled by a pulmonary impairment.

Causation of Total Disability

In order to be entitled to benefits, Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 C.F.R. § 718.204(c) (2005). Dr. Mullins' stated in her report that CWP contributed 75% to the Claimant's impairments. This evidence establishes the required causation.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 CFR § 725.503(b) (2005). The Claimant filed his claim for benefits in July 2001. When he was examined by Dr. Zaldivar in December 2001, he had a moderate irreversible obstruction. There is no opinion from Dr. Zaldivar whether that degree of obstruction was totally disabling. I note, however, that the job described by the Claimant required very heavy exertion. When the Claimant saw Dr. Mullins only four months later in April 2002, his performance on the pulmonary function tests had declined, and she said he was totally disabled. As I cannot determine the month of onset of disability, I find that the Claimant is entitled to benefits commencing in the month in which he filed his claim.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

The Claimant has met his burden to establish that he is totally disabled due to pneumoconiosis arising out of his coal mine employment. He is therefore entitled to benefits under the Act.

ATTORNEY FEES

The regulations address attorney's fees at 20 CFR §§ 725.362, 365 and 366 (2005). The Claimant's attorney has not yet filed an application for attorney's fees. The Claimant's attorney is hereby allowed thirty days (30) days to file an application for fees. A service sheet showing

that service has been made upon all parties, including the Claimant, must accompany the application. The other parties shall have ten (10) days following service of the application within which to file any objections, plus five (5) days for service by mail, for a total of fifteen (15) days. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by LANDON B. LUSK on July 12, 2001, is hereby GRANTED.

A

ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).